## ADJUSTER or TITLE PRELICENSING PROVIDER APPLICATION

Provider Name:		Provider #: For Departmental Us		
FEIN:				
	] Institution of Higher Learni ] Bona Fide Education School		Insurer	
	] Institution of Higher Learni ] Bona Fide Education School			
[] Public institution (Exempt from Fee)				
General Information: Mailing Address:				
Street or P.O. Box Street	City	State	Zip	
Address:Street	City	State	Zip	
Telephone# () Ex Fax# ()	1-800 (	)		
Name of Provider Representative (Contact )  E-Mail Address:  WEB Address:	First Name	MI	Last Name	
Courses to be offered:  [] Property & Casualty, Including V [] Property & Casualty, Excluding [] Workers Compensation [] Crop [] Title	-	-		
Signature of Provider Representative	re			
Sworn to and subscribed before me this	the day of		_, 20	
Notary Public		Commission Expires		
Notary Stamp Here	State of Alal Producer Lie P O Box 303	Mail Form and \$75 Initial Fee To:  State of Alabama Department of Insurance Producer Licensing Division/Prelicensing P O Box 303351 Montgomery, AL 36130-3351		